EUROPEAN INDICATORS FOR THE QUALITY OF LONG-TERM CARE: A GOOD IDEA?

Introduction

In this paper I will try to answer the question whether it is a good idea to develop European indicators for the quality of long-term care.
I write this paper from a Dutch perspective, the Netherlands being a country with a well-developed but very bureaucratised system of long-term care, still trying to overcome the effects of a great reform that was introduced three years ago.

What are indicators and how do they work?

Indicators are a measuring instrument. They are supposed to make it possible to give a quantitative assessment of a certain aspect of – in our case - long-term care.
There are usually a number of indicators which, together, constitute a quality system.
A first question about indicators that can be raised is: can the care process be described as consisting of quantifiable parts? Some parts certainly can be quantified: for instance the patient-staff ratio, but there are other parts that are much more difficult if not impossible to quantify, for instance the bed-side manners of professionals. In some cases it is tried to find "substitutes" which are supposed to represent the item that is difficult to measure. In our example this could be the amount of time the professional spends talking with the patient, but does that represent bed-side manners?
This means there are two questionable aspects of describing the quality of care in quantitative terms. One is that only part of the care process can be measured but that other vital elements cannot be taken into account and the other is that some indicators that are used do not really represent what they are supposed to measure.
A second problem with indicators is that they are usually based on self-reporting. Professionals are required to report how they have performed and we know that self-reporting often leads to more positive outcomes than reporting by a third party. So: how reliable are the data obtained with indicators?
And a third problem is that indicators have a tendency to become a steering instrument. Organisations want to get high scores on the indicators being used, so the professionals must adapt their work to ensure that the highest possible scores on the indicators are obtained. But what is good for the organisation is not necessarily good for the patient. For instance: the length of stay in hospital is used as an indicator of the quality of care of the hospital. The consequence is that the hospital shoves out patients before they are ready to leave without minding that many have to be readmitted because they were discharged too early. With two short hospital stays of the same patient the hospital scores better than with one longer stay.
This is a rather dangerous consequence of using indicators: the organisation may then be steered by indicators, but indicators only map part of what quality is and use false representations of other aspects of quality. Thus the indicators may show that a care provider delivers excellent care whereas the hands-on workers and patients are convinced that the care that is provided is by far not as good as it could (and should) be.
Conclusion: indicators are not a good instrument to measure quality of long-term care and they can have the perverse effect of being turned into goals instead of only being used as a measuring instrument.

Is it useful to develop quality systems? An experience from The Netherlands

In The Netherlands the idea that it is necessary to monitor the quality of care has been embraced and this has led to many quality systems. Different governmental agencies having to do with long-term care services as well as the large care providing companies themselves have developed quality systems so care workers have to meet the requirements of these various systems, and they have to collect data on safety, hygiene, professionality and many other items. They have to deal with

protocols, check lists and questionnaires. Personnel in the long-term care sector now spends up to 40% of their time with paper work and other bureaucratic duties and their complaints are loud and many. They do not want to work for systems they want to work for patients.
It now has been sufficiently proved that working with quality systems is not necessarily helpful, it can be rather dysfunctional, because the hands-on workers see that they have to meet criteria that are not adapted to the particular situation of the patients and the setting where they work.
Of course it is necessary that there are checks on how care services perform but these systems should not dominate the work and it should be critically monitored whether they really result in an improvement of the quality of care. Only too often institutions try to obtain a quality label, because that is good for their reputation, where in reality the quality of care has become less adapted to the needs of individual clients.
If different quality systems are used simultaneously this may be confusing for workers and it usually brings about more paper work that workers experience as a burden because it keeps them from doing what they define as their real task: to work according to their own professionality and spend as much time as possible with and for patients and not with bureaucracy.
In the Netherlands we are now trying to put the patient in the centre and to reduce paper work, so that workers will have more time for patients, but systems often prove more powerful than patients.
We can learn from the example of The Netherlands is that we really should think twice before introducing more quality systems.

Is it useful to develop <u>European</u> indicators for long-term care?
Europe has adopted the Pillar of Social Rights and Social Right 18 reads as follows: Everyone has the right to affordable long-term care services of good quality, in particular home-care and community-based services.
Does that mean that there is a role for Europe in developing European indicators with a view to improving the quality of long-term care?
Some people seem to think the answer is yes. But is it? The idea is that the quality of long-term care in some countries is rather low and that it can be improved by developing European indicators for the quality of long-term care. Apart from the objections against the use of indicators raised above, we should recognise that care has a lot to do with culture, with norms and values, with the economic situation, the legislative framework and local conditions. Will European indicators be able to take all these factors into account as well? That seems asking for the impossible. So would European indicators be good guidelines for workers to provide better long-term care all over Europe and suitable in each individual case? This seems hardly imaginable. By introducing European indicators for long-term care we are likely to require hands-on workers to work according to guidelines which they feel are inappropriate in their particular situation.
Besides, by introducing European indicators we convey the message that it is more important to work for a system than to put the particular needs of each individual patient at the centre. By introducing indicators to measure the quality of long-term care Europe gives the wrong message.

There is still a totally different reason why European indicators as a means to improve the quality for long--term care is not a good idea and that is the principle of subsidiarity: Europe should not take on tasks which can better be performed by national states.
The responsibility for ensuring that long-term care is of good quality should be left to national states. Europe should not set standards or develop indicators for the quality of long-term care for all the Member States but should see to it that Member States devise adequate measures to monitor the quality of long-term care and that they take action in case of insufficient quality.

The question we posed at the beginning of this paper whether it is a good idea to develop European Indicators for the quality of long-term care can be answered with a clear: NO.

What can Europe do?

If Europe should not go ahead and develop indicators for the quality of long-term care, what can Europe do more than ensure that Member States require long-term care services in their respective countries to live up to standards? The best chances for Europe to play a positive role in the care sector lies in research and development and in dissemination and implementation of the results. Soft methods to learn and improve.
Maybe we should set out by asking ourselves simple questions such as: what do we mean by good quality of long-term care? And: is that the same all over Europe?
What do patients see as the most important elements that contribute to high quality of long-term care? Do they differ from what the various professionals in the long-term care system consider as important elements?
What expectations do long-term care systems have of informal carers? To what extent and how do these expectations have an influence on the quality of long-term care?
Already many quality systems are being used in several countries. What are the experiences of patients with these systems? How do professionals experience the use of quality systems?
A comparison can be made between systems and it can be studied what positive and negative effects they have.
What legislation influences the quality of care (e.g. legislation on elder abuse, on privacy)? What are positive and what are negative effects of legislation? Depending on the outcomes: should more legislation be initiated and if so, on which issues?
Certainly many other questions will come up, once we start working on the issue.
Europe can also commission overview studies, bringing together what we already know about key issues in long-term care.
A problem with research is that it is difficult to get the results implemented. Researchers make recommendations at the end of their reports and often discuss them with those who commissioned the research but there it stops.
One way to improve the implementation of the results of research and development would be to work with students and their teachers. Once new ideas are implemented in the educational and training programmes of future professionals in long-term-care they are more likely to eventually be put into practice.
Europe could set up projects for researchers and professional colleges where researchers get the task of making their findings known to teachers and students in these colleges. Such projects could prove to be the missing link between research on the one hand and policy and practice on the other.
Once it has been agreed what good quality of long-term care is, Europe could initiate training courses for teachers of professional colleges.
The open method of coordination which has been used in the past in the social sector can also pave the way for introducing new and better ways of working if it were applied on a large enough scale and would involve both high level policy makers and those who have experience in practice.
The above shows there are certainly ways in which Europe can contribute to the quality of long-term care, other than working with indicators.

At the end, one caveat: I wish that my paper turns the tide in Europe so that the idea to develop European indicators for the quality of long-term care will be abandoned but I am afraid that this is not going to happen: already too many agencies have a stake in the process. So when these indicators have been produced the first thing that should happen before they are put into practice is that they should be tested with the hands-on professionals and the patients in all Member States and that the outcomes of these tests should be taken very seriously in order to prevent Europe from taking counterproductive measures.

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